Arizona Dental Sealant Program
For SCHOOL YEAR 2004-2005
Please fax by May 14, 2004
(Complete one form per school)

Contact Person:
Name: _____
Title: _____
(e.g., School Nurse, Principal, Health Aide, Secretary, Head Teacher, Administrator)
Phone: _____Fax: _____E-mail:_____

School Information:
School Name: _____
Street Address: _____
City: _____ Zip: _____
County: _____ Telephone Number: _____
School District: _____

Please report Mailing Address below, if it is different from Street Address:

_____
_____
City _____ Zip _____

1. Percentage of students at this school on free or reduced lunch program: _____%
   ☐ No free or reduced lunch program at this school

2. Number of students in grade 2: _____
3. Number of students in grade 6: _____

Optional information not required for application:
Although you are not required to answer the following questions as part of the application process, the Sealant Program Coordinator will need the following information in order to schedule your school if it is selected for participation.

4. The school day usually begins at: _____ A.M.
5. The school day usually ends at: _____ P.M.

6. The school year is scheduled to begin on _____ (date) and end on _____ (date)
7. Is this a year round school? Yes No
8. What day(s) of the week are best to schedule the sealant program?
9. Would you prefer the sealant team to come to your school in the fall or spring?
   Fall Spring

10. Are there any other scheduling situations of which we should be aware?

11. Would you submit an application online for this program if it were on the web next year? __Yes __No

Please return this application by fax to: 602-506-3081 Attn: Kathy Graham by **May 14, 2004**